DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0421	A. BUILDING _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB CENTER AT BRISTOL	109 VILLAGE CIRCLE BRISTOL, VA 24201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/9/19 through 5/10/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced initial certification survey was conducted 5/9/19 through 5/10/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 120 certified bed facility was 5 at the time of the survey. The survey sample consisted of 5 current Resident reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and new employee file review, the facility staff failed to obtain a criminal background check on 1 of 25 newly hired employees of the facility	F 607	1. The identified employee (employee #20) background check was rechecked on 5/10/2019. The results of background check were clear. 2. 100% of employee files were checked for timely background checks on 5/10/2019. Background checks were all in compliance and completed within 30 days of hire. 3. HR manager or designee will complete Employee Background Check prior to date of hire. On 5/10/2019 Administrator in-serviced office staff on background checks being completed prior to date of hire. 4. Administrator will audit new employee files for 90 days for background completion prior to hire date. The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. 5. Date Resolved: 5/11/2019	5/11/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Wynn — TITLE: Administrator — (X6) DATE: 6/5/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 607	Continued From page 1 (Employee #20). The findings included: The surveyor performed a review of the newly hired employees on 5/10/19 and it was noted that Employee # 20 had been hired as the administrator for the facility on 9/10/18. The criminal background check was not completed until 10/24/18, which was 44 days after the hire date. The surveyor notified the administrator of the above documented findings on 5/10/19 at 1 pm. The administrator stated, "I was hired back in September but the building was not opened until February. I was being paid out of a different account then in October. I was switched to being paid from this facility." The surveyor requested to speak to the corporate human resource staff to clarify this. At 1:30 pm, the surveyor spoke to the corporate human resource employee that stated that Employee #20 had been hired on 9/10/18 as the role of administrator for the Bristol building. The administrator was being paid out of a different part of the corporation until 10/24/18 at which time the administrator's pay was changed to reflect she was being paid by the Bristol facility." The surveyor asked the corporate human resource employee three times if Employee #20 had been hired in September 2018 for the role of administrator of the Bristol facility. The corporate human resource employee stated, "Yes, she was hired as the administrator for the Bristol facility." The surveyor reviewed the facility's policy titled, "Abuse Prevention Program" which read in part:	F 607		

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F 607	Continued From page 2 " " ...As part of the resident abuse prevention, the administration will: ...Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: " Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law ..." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 5:30 pm. No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 607		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician's orders for administration of a blood pressure medication for 1 of 5 residents in the survey sample (Resident #3). The findings included: The facility staff failed to obtain a blood pressure to determine if the blood pressure medication	F 684	1. PRN blood pressure order for Resident #3 was discontinued on 2/21/19. Resident's blood pressure readings taken between 2/1/19-2/21/19 were reviewed and found to be below the parameters set in the PRN medication order. Resident did not require the PRN blood pressure medication for the parameter set in the order. Physician reviewed vital signs on 2/21/19 and discontinued order. 2. 100% of residents' orders were reviewed on 5/10/19. There were no found PRN Blood Pressure medications that required parameters. 3. New physician orders and Medication Administration Records will be checked daily. Any PRN blood pressure medication will have a scheduled blood pressure reading to correspond with the hours of administration. On 5/10/19 licensed nursing staff was in-serviced by DON and ADONs on "Placing parameters on PRN Blood Pressure Medications". 4. DON or designee will audit new orders daily for 90 days to verify prn blood pressure medications with parameters have a scheduled blood pressure reading to correspond with the hours of administration. The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. 5. 5/11/2019	5/11/2019

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F 684	Continued From page 3	F 684		

should be given to Resident #3 as ordered by the physician.

Resident #3 was admitted to the facility on 2/1/19 with the following diagnoses of, but not limited to high blood pressure, dementia, Alzheimer's disease, anemia, adult failure to survive and major depressive disorder. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/7/19, the resident was coded as having short term and long term memory problem, and being moderately impaired in daily decision making. Resident #3 was also coded as requiring extensive assistance of 1-2 staff members for dressing, personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review on 5/9 and 5/10/19, the surveyor noted the following physician order for Resident #3:

" Hydralazine 10 mg (milligram) 1 tablet every 6 hours prn (as needed) for SBP >160 or DBP >100.

This physician order had the start date of 2/11/19 and end date of 2/21/19. The surveyor reviewed the resident's MAR (Medication Administration Record) for February 2019 concerning the administration of the above stated high blood pressure medication. The surveyor noted there were no blood pressures documented every 6 hours for this resident. The surveyor however, noted documentation of the resident's blood pressures once or twice a day in the vital signs area of the clinical record from 2/11/19 to 2/21/19.

The surveyor notified the DON (director of

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F 684	Continued From page 4 nursing) of the above documented findings on 5/10/19 at 11 am. The DON stated, "We would only take the blood pressure if we thought the resident was having problems with her blood pressures." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 5:30 pm. No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	**1.** The following medications for Resident #1 were available and administered by 11:00am on 2/5/19 per physician's order to give on arrival: Acidophilus capsule 1 PO, Aspirin 81mg, Claritin 10mg, Ferrous Sulfate 325mg, Coreg 3.125 mg, Escitalopram 10mg, Lasix 40mg, Hyoscyamine 0.125mg, Omeprazole 40mg, Plavix 75mg, and Potassium Chloride. The following medications for Resident #1 were available on 2/9/19 according to pharmacy manifest with a delivery date of 2/5/19 at 9:12 p.m.: Acidophilus 1 capsule PO, Aspirin 81 mg, Claritin 10mg, Escitalopram 10mg, Lasix 40mg, Hyoscyamine 0.125mg, Plavix 75mg, and Potassium Chloride 20 meq. Medications were administered at 10:18a.m. on 2/9/19. MD was notified of medication given outside of timeframe. Hydralazine 10mg was available and administered to Resident #3 at 1:45 a.m. on 2/10/19. MD was notified of medication given outside of time-frame.	**5/11/2019**

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F 755	Continued From page 5 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available to be administered to 3 of 5 residents in the survey sample (Resident #1, #3 and #4). The findings included: 1. The facility staff failed to ensure medications were available to be administrated to Resident #1. Resident #1 was admitted to the facility on 2/1/19 with the following diagnoses of, but not limited to heart failure, high blood pressure, paraplegia, low potassium levels, Ankylosing spondylitis and osteoarthritis. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #1 was also coded as requiring extensive assistance of 1-2 staff members for dressing and personal hygiene and being totally dependent on 1-2 staff members for bathing. During the clinical record review for Resident #1 on 5/10/19, the surveyor noted on the MAR (Medication Administration Record) that the	F 755	1. Continued from page 5 Lactulose was available and administered to Resident #4 at 5:47a.m. on 2/27/19 per physician's order to give on arrival from pharmacy. 2. Reviewed 100% residents' orders and determined all resident medications were available, verified by Medication Administration Record (MAR) compared to medication available on each medication cart. On 5/10/19, licensed nursing staff was in-serviced by DON and ADONs on obtaining medication when not available at time of med pass. On 5/10/19, licensed nursing staff was retrained by DON and ADONs on use of eMar system when administering medications. 3. Medication Room was stocked with an additional Emergency Kit to increase medication availability. On 5/10/19, licensed nursing staff was in-serviced by DON and ADONs on availability of new emergency kit in the medication room. 4. DON or designee will perform audits of resident new medication orders to ensure medication is available. DON or designee will perform audits of medication room to ensure Emergency Kits are in medication room and stocked. Audits will be performed twice a week for 90 days. The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. 5. 5/11/2019	5/11/2019

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F 755	Continued From page 6 following medications were documented as the medication was not available from pharmacy to administer to Resident #1: " Acidophilus capsule 1 po (by mouth) BID (twice a day) was not available on 2/5/19 at 9:00 am and 2/9/19 at 10:18 am. " Aspirin 81 mg (milligram) once a day was not available for administration on 2/5/19 at 11:00 am and 2/9/19 at 10:18 am. " Claritin 10 mg once a day was not available for administration on 2/5/19 at 11:00 am and on 2/9/19 at 10:18 am. " Coreg 3.125 mg twice a day was not available for administration on 2/5/19 at 11:00 am. " Escitalopram 10 mg once a morning was not available for administration on 2/5/19 at 9:00 am and on 2/9/19 at 9:00 am. " Ferrous Sulfate 325 mg twice a day was not available for administration on 2/5/19 at 9:00 am. The comment that was documented read, "ordered per MD to give medications together when all arrived fat facility." " Lasix 40 mg once a day was not available for administration on 2/5/19 at 9:00 am, and on 2/9/19 at 9:00 am. " Hyoscyamine 0.125 mg twice a day was not available for administration on 2/5/19 at 9:00 am and 2/9/19 at 9:00 am. " Omeprazole 40 mg once a day on Sunday, Tuesday and Thursday was not available for administration on 2/5/19 at 9:00 am " Plavix 75 mg once a day was not available for administration on 2/5/19 at 9:00 am and on 2/9/19 at 9:00 am. " Potassium Chloride 20 meq 2 tablets once a day was not available for administration on 2/5/19 at 9:00 am and on 2/9/19 at 9:00 am.	F 755		

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F 755	Continued From page 7 The surveyor notified the administrative team of the above documented findings on 5/10/19 at 4:30 pm. The surveyor requested a copy of the medication manifest from the pharmacy for the above documented findings. The DON stated, "I don't know if the medication was here and it was a charting issue by the nurses or if the medication was not in the facility at the time that it was to be given." At 5:00 pm, the DON (director of nursing) gave a copy of the manifest from the pharmacy to the surveyor. It was noted by the surveyor that the above documented medications were delivered to the facility on 2/5/19 at 9:12 pm. No further information was provided to the surveyor prior to the exit conference on 5/10/19. 2. The facility staff failed to ensure that a blood pressure medication was available to be administrated to Resident #3. Resident #3 was admitted to the facility on 2/1/19 with the following diagnoses of, but not limited to high blood pressure, dementia, Alzheimer's disease, anemia, adult failure to survive and major depressive disorder. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/7/19, the resident was coded as having short term and long term memory problem, and being moderately impaired in daily decision making. Resident #3 was also coded as requiring extensive assistance of 1-2 staff members for dressing, personal hygiene and being totally dependent on 1 staff member for bathing.	F 755		

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F 755	Continued From page 8 During the clinical record review on 5/10/19, the surveyor noted that the resident did not receive the following medication: " Hydralazine 10 mg (milligram) twice a day was not available for administration on 2/9/19 at 9:00 pm. The comment that was documented stated "waiting on arrival of medication delivery." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 4:30 pm. The surveyor requested a copy of the medication manifest from the pharmacy for the above documented findings. The DON stated, "I don't know if the medication was here and it was a charting issue by the nurses or if the medication was not in the facility at the time that it was to be given." The surveyor did not receive a copy of the manifest from the pharmacy that had been previously requested. No further information was provided to the surveyor prior to the exit conference on 5/10/19. 3. The facility staff failed to ensure that the medication, Lactulose, was available to be administrated to Resident #4 as ordered by the physician. Resident #4 was admitted to the facility on 2/2/19 with the following diagnoses of, but not limited to Alzheimer's disease, osteoarthritis, diabetes, dementia and high blood pressure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/2/19, the resident was coded as having short term and long term memory problems and being moderately impaired in making daily decisions. Resident #4	F 755		

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F 755	Continued From page 9 was also coded as requiring extensive assistance from 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. During the clinical record review on 5/10/19, the surveyor noted the resident did not receive the following medication: " Lactulose 20 gram /30 ml (milliliter) once a day was not available for administration on 2/26/19 at 9:00 pm. This medication was noted to be documented on 2/27/19 at 5:47 am, which stated, "Administrated late ...Medication just arrived by pharmacy." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 4:30 pm. The surveyor requested a copy of the medication manifest from the pharmacy for the above documented findings. The DON stated, "I don't know if the medication was here and it was a charting issue by the nurses or if the medication was not in the facility at the time that it was to be given." The surveyor did not receive a copy of the manifest from the pharmacy that had been previously requested. No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 10 by: Based on observation and clinical record review, the facility staff failed to ensure the medication error rate was less than 5% on 1 of 2 units in the nursing facility. (Unit 2, second floor) The medication error rate was noted to be 8.69%, which included 2 medication errors out of 23 opportunities for errors. The findings included: The facility staff failed to ensure the medication error rate was less than 5% on Unit 2, second floor. The medication error rate was noted to be 8.69%, which included 2 medication errors out of 23 opportunities for errors. Resident #4 and Resident #1 were the residents in which the nurse made the errors on. On 5/9 and 5/10/19, the surveyor performed the facility task for medication administration observation. On 5/10/19 at 8 am, the surveyor observed LPN (licensed practical nurse) #2 administrated Symbicort inhaler to Resident #4. LPN #2 gave the resident water after the use of the inhaler and the resident swallowed the water. LPN #2 did not give instructions to the resident not to swallow the water that she was being given nor did she have another cup for the resident to spit the water into after she had rinsed her mouth. The surveyor noted on the medication label on the inhaler box read in part " ...Do not swallow/rinse afterward ..." LPN #2 went to Resident #1 at 8:20 am and administrated Symbicort inhaler as ordered by the physician. LPN #2 gave the resident water after the use of the inhaler and the resident swallowed the water. LPN #2 did not give instructions to the	F 759	**1.** Resident #1 and Resident #4 were immediately assessed for adverse reactions to swallowing the rinse water. LPN #2 was immediately educated on technique for prompting resident to rinse with water after administration of the inhaler. **2.** DON reviewed all resident orders and determined no other residents have orders for inhalers at this time. **3.** On 5/10/19, licensed nursing staff was in-serviced by DON and ADONs on medication administration for steroid inhaler to include rinsing and spitting. **4.** Director of Nursing or designee will perform 2 random medication administration passes per week for 90 days to observe inhaler administration for rinsing, spiting, and use of basin. The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. **5.** 5/11/2019	**5/11/2019**

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F 759	Continued From page 11 resident not to swallow the water that he was being given nor did she have another cup for the resident to use to spit the water in after he had rinsed his mouth. The surveyor noted on the medication label on the inhaler box read in part " ...Do not swallow/rinse afterward ..." The administrative team was notified of the above documented findings on 5/10/19 at 5:45 pm. No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761	1. Larger medication refrigerator with permanent locked narcotic box was moved into place in Med Room on 5/9/2019. 2. Reviewed 100% of resident's physician orders and determined that no residents currently have orders for narcotics that require refrigeration. No residents were affected. 3. Medication Room Checklist was updated to include verification of lockable narcotic box securely placed in refrigerator. The Charge nurse on duty completes Medication Room Checklist daily. On 5/10/19, licensed nursing staff was in-serviced by DON and ADONs on maintaining refrigerated narcotics in a closed narcotic box. 4. DON or designee will check Medication Room Checklist for completion and verify permanent lock box is in refrigerator two times a week for 90 days. The results of these reviews will be discussed monthly in QAPI meetings for effectiveness of these measures and modified as necessary. 5. 5/11/2019	5/11/2019

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F 761	Continued From page 12	F 761		

quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to have narcotic box in the medication refrigerator permanently affixed for 1 of 2 units in the nursing facility (Unit 2 on second floor).

The findings included:

The facility staff failed to have a permanently affixed narcotic box in the medication refrigerator on Unit 2, which is on the second floor of the nursing facility.

On 5/9/19, the surveyor observed that in the medication refrigerator located on Unit 2, second floor of the facility, did not have a permanently affixed narcotic box. This box would be where narcotics that needed to be refrigerated would be stored. Unit Manager #2 was with the surveyor when the above finding was noted. Unit manager #2 stated, "I will bring this to the director of nursing's attention."
At approximately 10:20 am, the director of nursing (DON) came to the surveyor and stated, "We knew we needed one but because we didn't have any narcotics at the present time to be stored in the refrigerator it was not put into place. We had a backup plan for the time that this would be needed to be installed."

On 5/10/18 at approximately 5:30 pm, the surveyor notified the administrative team of the above documented findings. The administrator stated, "We had a plan in place for when we needed to store narcotics in the refrigerator. I

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F 761	Continued From page 13 went ahead and had maintenance put in a bigger refrigerator and have box in there for the narcotic storage. We just wasn't going to do this until we needed to." No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to date spices after they have been opened in the facility kitchen. The findings included:	F 812	1. Spices labeled with an open date were thrown away. 2. Dietary manager checked the rest of the kitchen and discarded any items with an open date that was not required to have an open date. On 5/10/19, Dietary manager in-serviced dietary staff regarding policy on labeling, dating, and expiration dates. 3. Dietary manager posted a "Food Storage & Retention Guide" above the spices and throughout kitchen. Dietary Manager or designee will check that all food items are dated correctly daily using form "Opening Checklist." On 5/10/19, Dietary Manager in-serviced dietary staff on Food Storage & Retention Guide and the use of Opening Checklist to check labeling and dating on a daily basis. 4. Dietary District Manager will perform weekly audits for 90 days to check that all food items are labeled and dated according to Food Storage & Retention Guide. The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. 5. 5/11/2019	5/11/2019

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F 812	Continued From page 14 The surveyor went into the facility's kitchen and conducted an initial tour on 5/9/19 at 11 am. At this time, the surveyor noted that the following spices had not been dated after they were opened: " Ground Mustard 15 oz. (ounce) container " Ground Cinnamon 18 oz. container The surveyor asked the dietary manager when these opened spices should be discarded. The dietary manager stated, "I have a list in my office that is from the manufactory and I go by those recommendations." The surveyor asked how would kitchen staff know when these spices were opened so staff would know when to discard the spice if the recommendation stated it should be discarded 6 months after it had been opened. The dietary manager stated, "The containers should have a date written on it when it was opened." The surveyor asked if there were any dates on these 2 spice containers. The dietary manager stated, "No, but I can write it on them right now." The surveyor asked the dietary manager if he knew when these spices were opened. The dietary manager replied, "No, but I can just date it with today's date." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 5:30 pm. No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

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F 842	Continued From page 15 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	1. On 2/19/19,Facility identified missing data on "Post Fall 72 Hour Monitoring Report" and charge nurse immediately checked vital signs for Resident #5 which were within normal limits. 2. Director of Nursing checked "Post Fall 72 Hour Monitoring Report" for previous falls. The reports were completed according to the instructions. 3. Facility implemented a new neuro check assessment form that is compatible with facility's policy. On 5/10/19, licensed nursing staff was educated by DON and ADONs on initiating and completing Neuro Check Assessment Form. 4. Director of Nursing or designee will audit completed Neuro Check Assessment Forms for completion after each fall for 90 days.The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. 5. 5/11/2019	5/11/2019

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F 842	Continued From page 16 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 5 residents in the survey sample (Resident #5). The findings included: The facility staff failed to ensure a complete and accurate clinical record in regards to the post monitoring documentation of a fall for Resident #5, which occurred on 2/19/19. Resident #5 was admitted to the facility on	F 842		

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F 842	Continued From page 17	F 842		

2/11/19. Diagnoses included but were not limited to dementia with behaviors, palliative care and kidney disease. On the admission, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/18/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 4 out of a possible score of 15. Resident #5 was also coded as requiring extensive assistance of 1-2 staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

During the clinical record review on 5/10/19, the surveyor noted that Resident #5 had a fall on 2/19/19 at 4 pm. On the "Post Fall 72-Hour Monitoring Report", the surveyor noted that there were boxes that were left blank. These blank boxes were for the following:

" On 2/19, there was no documentation of vital signs for 5:05 pm, 5:20 pm, 5:50 pm boxes on this form.
" At 6:20 pm and at 6:50 pm, the vital signs were not obtained as directed on the form.
" There were no vital signs documented, the boxes were left blank for the 48 and 72 hours post fall assessment.

On the "Post Fall 72-hour Monitoring Report" the surveyor noted the following instructions for staff to follow which read in part " ...Initial assessment (B*); followed by q (every) 15 min (minutes) X4; q30 min X 2; every hour X 2; once per shift for 72 hours ..."

The surveyor notified the administrative team of the above documented findings on 5/10/19 at 5:45 pm. The surveyor asked the DON (director of nursing) what her expectation was for the

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F 842	Continued From page 18 nurses to follow when documenting on the facility's "Post Fall Monitoring Report. The DON stated, "They are to follow the instructions for documentation as described in the directions on the form." No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	1. LPN #2 immediately disinfected stethoscope using proper cleaning procedures, prior to use on another resident. 2. All stethoscopes in each medication cart were disinfected. Director of Nursing did one on one education with LPN #2 on facility infection control procedure and proper cleaning and handling of stethoscope during medication administration. 3. Infection Control training to licensed nursing staff on proper handling and cleaning of stethoscope during medication administration was done by DON and ADONs on 5/10/19 and will be conducted upon hire and annually. 4. Director of Nursing or designee will perform 2 random medication administration pass observations per week for 90 days to observe proper cleaning and handling of stethoscope. The results of these reviews will be discussed monthly for 3 months at the QAPI meetings for effectiveness of these measures and to modify as necessary. 5. 5/11/2019	5/11/2019

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F 880	Continued From page 19 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical	F 880		

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F 880	Continued From page 20	F 880		

record review, the facility staff failed to follow infection control guidelines for 2 of 3 residents during the medication administration observation (Resident #1 and #2).

The findings included:

1. The facility staff failed to follow infection control guidelines concerning the cleaning of a stethoscope during the medication administration observation for Resident #1.

Resident #1 was admitted to the facility on 2/1/19 with the following diagnoses of, but not limited to heart failure, high blood pressure, paraplegia, low potassium levels, Ankylosing spondylitis and osteoarthritis. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/4/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #1 was also coded as requiring extensive assistance of 1-2 staff members for dressing and personal hygiene and being totally dependent on 1-2 staff members for bathing.

During the medication administration observation on 5/10/19 at 8:20 am, the surveyor observed the following performed by LPN (licensed practical nurse) #2:

" LPN #2 took her stethoscope out of her shirt pocket and listened to Resident #1's chest and abdomen. She then placed the stethoscope back into her pocket.

" LPN #2 went into the resident's bathroom and washed her hands. Upon her return to the medication cart located just outside of the

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F 880	Continued From page 21 resident's door, she wiped the stethoscope off with a sanitizer wipe and placed it around her neck. The surveyor requested on 5/10/19 at approximately 11 am and received the facility's policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" which read it part: " " ...Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) ... " Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident ..." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 5:45 pm. No further information was provided to the surveyor prior to the exit conference on 5/10/19. 2. The facility staff failed to follow infection control guidelines concerning the cleaning of a stethoscope during the medication administration observation with Resident #2. Resident #2 was admitted to the facility on 2/21 19 with the following diagnoses of, but not limited to dementia, osteoarthritis, major depressive disorder, high blood pressure, COPD (chronic obstructive pulmonary disease) and anxiety disorder. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/11/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 8 out of a possible score of 15. Resident #2 was also	F 880		

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F 880	Continued From page 22 coded as requiring limited supervision of 1 staff member for dressing and personal hygiene and extensive assistance of 1 staff member for bathing. The medication administration observation made by the surveyor on 5/10/19 at 8:45 am, the surveyor observed the following performed by LPN (licensed practical nurse) #2: o LPN #2 took her stethoscope out of her shirt pocket and listened to Resident #1's chest and abdomen. She then placed the stethoscope back into her pocket. o LPN #2 went into the resident's bathroom and washed her hands. Upon her return to the medication cart located just outside of the resident's door, she wiped the stethoscope off with a sanitizer wipe and placed it around her neck. The surveyor requested on 5/10/19 at approximately 11 am and received the facility's policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" which read it part: o " ...Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment) ... o Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident ..." The surveyor notified the administrative team of the above documented findings on 5/10/19 at 5:45 pm. The DON and administrator stated to the surveyor that they had interviewed the nurse and the nurse states that she did follow infection control guidelines regarding the use of her stethoscope. The surveyor stated, "The problem	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0421	A. BUILDING _____ B. WING _____	05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 was the nurse put the dirty stethoscope in her pocket of her shirt, washed her hands then when she returned back to the medication cart, the nurse took the dirty stethoscope out of her shirt pocket and wiped it down with a cleaning wipe." No further information was provided to the surveyor prior to the exit conference on 5/10/19.	F 880		